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ABSTRACT

This monograph presents a model for team assessment of student learning problems which stresses the inclusion of all relevant parties in the assessment process and incorporates the frequently neglected factor of students' physical health. An eight-step intervention sequence is presented which includes: (1) listening to the student describe his or her problem, (2) observing the student at work, play, and rest in the home and at school, (3) conducting an initial conference among those who interact regularly with the student, (4) determining the initial remediation of the problem, (5) making a medical referral when necessary, (6) making accurate anecdotal materials available to the clinic, agency, or physician, (7) having the clinic or medical facility provide information to the patient and appropriate other adults, and (8) scheduling follow-up meetings with the original conference members and any additional specialists who might assist with the proposed remediation. Procedures and considerations for choosing, evaluating, and utilizing medical and psychological referral sources are described and a three-page form for evaluating these possible referral sources is included. Several case histories illustrating the eight steps in the intervention schedule are presented. (JMB)

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STUDENT HEALTH: THE MISSING LINK IN THE REFERRAL PROCESS

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ABSTRACT

This monograph contains a model for a team approach to student assessment and the development of appropriate I.E.P.s. The model contains a format for evaluating medical and psychological referral sources which may be utilized by school personnel and presents several case histories which illustrate the commonality of overt symptoms for both physical and psychological problems in school aged children.

Section I

When a child of average academic ability fails to learn, the child's parents become concerned about the quality of education, peer relationships and their own home life. The school counselor considers psychological assessment and the possibility of therapy. Teachers review their teaching methods, wonder about the child's home life and peers and hope for an answer in the cumulative folder.

Obviously, neither the whole problem nor the whole child is visible, and this youngster is in danger of becoming as fragmented as a jig-saw puzzle while his or her parents define the problem from their viewpoints and school personnel apply remediations based on their conceptualization of the concern. Everyone is determined to set things to right; but this hit and miss process does not allow for a holistic definition of the situation.

Early on, those involved in remediation must meet together. School counselors are trained to provide parents and teachers with the climate and opportunity to share whatever seems relevant to the child's problem. In the absence of counselors, any caring adult may take the initial steps towards establishing a comprehensive consultation procedure.

At the outset of this consultation process, parents and school personnel should examine each and every seemingly unrelated aspect of the difficulty, then reconsider separate conclusions incorporating each other's perspectives. However, even if those involved are absolutely accurate in their individual assessments, a part of the puzzle, physical state, will be missing; and, without this vital information, the child could be subjected to superficial intervention procedures.

Health is a neglected consideration within most team approaches to remediation. School counselors are trained to consult with parents and pupil personnel workers but a recent review of elementary school counselor preparation showed no specific training about the role which physical symptoms play in the diagnosis of children's problems (Wherly, 1970). Few teacher training programs include the recognition of the symptoms of common childhood diseases: medical personnel are rarely available at the school site. Economic factors have eliminated or restricted the availability of many other types of specialists who do have training within medical areas.

Health has been further removed from the realm of concerns appropriate to school personnel by state or local laws which require periodic medical examination of school-aged children. Such laws seem to encourage educators to presume that all doctors examine all children carefully; and that all parents know what kinds of information to report to insure that a given child receives a thorough examination. The ramifications of such thinking are dangerous. Actually, school personnel have no guarantee that a majority of existing school health records accurately reflect the health status of individual students.

In the author's experience, one such record indicated that a boy, blind in one eye since birth, had 20/20 vision in both eyes. He had adapted to his visual handicap so well his parents did not mention the loss to their new physician or to the school authorities. Further, some family doctors were willing to fill out health records for students whose parents dropped the forms, but not the students, at the doctor's office.

Nevertheless, laws requiring mandatory physical examination should not be repealed or weakened; rather, parents and educators must insist upon the

actual services such examination implies. Laypersons need to examine their expectations of medical services and personnel, recognize existing weaknesses, and discount romanticized myths or beliefs which cannot be factually supported. Parents and educators should seek out those physicians who are dedicated to the welfare of children and work as a team toward improving the health of school-aged children.

A pattern seems to emerge when we examine how false assumptions are made about a child's health. As both adequate income and mandatory physical examination come together, inferences are drawn which eliminate health as part of the problem. Poverty precipitates and perpetuates poor health such that if a youngster comes from a large family and lives in a run-down neighborhood, that child's health is generally evaluated. When the case involves a middle-class child, unverified assumptions about good health introduce the possibility that important physical signals are either misperceived or ignored.

If an educator first assumes physical health, because the child has had routine medical care, and further assumes any difficulty must be psychological in nature, then the child's distress will be prolonged by decisions which divert the focus of remediation to peripheral (but genuine) aspects of the problem. Educators' decisions affect children's lives and most of these judgements are routine, valid attempts to make problems more manageable. Because of work loads and time restrictions, however, this thrust sometimes switches from an emphasis on manageability for the person with the problem to an emphasis on manageability for those called upon to provide remediation. Schools must accept then another responsibility. Those who have daily contact with children need an awareness of the heightened possibility for misinterpretation of physical symptoms when those symptoms occur in the school setting.

Laypersons should not attempt to diagnose or prescribe in medical and psychological areas, of course. They should, however, be willing to look beyond the obvious, to become aware of the inherent complexity of humans and their difficulties. A young person, with an accurately defined emotional or learning problem, may also exhibit secondary physical symptoms such as headache or abdominal involvement. These same signs, when inaccurately diagnosed, may indicate health problems ranging from faulty vision to brain tumor. Every possibility should be thoroughly explored before any remediation is attempted.

Section II

Parents and educators often become aware of the need for referral sources with capabilities beyond those of school and home after they become involved with a particular child. One such resource is the facility which specializes in the diagnosis of childrens' emotional and/or physical problems. A procedure for locating and evaluating these facilities, before the need arises, will be discussed later.

Comprehensive case evaluation allows for a definitive diagnosis so that intervention focuses on the core, rather than on the symptoms, of the young person's dilemma. The following intervention sequence stresses the dependency between physical and psychological health and suggests points in the referral process when physical state is examined as carefully as are psychological and cognitive development.

Intervention Schedule:

Step 1: An adult listens to a young person describe the difficulties, feelings, behaviors or physical signs which are troubling to him or her.

The key work in this step is "listens". Listening differs from hearing-

out in that listening alters both the receiver's prior conceptions of a problem and any subsequent response. Hearing-out does not alter either prior opinions or predetermined reactions. Listening establishes the essential trust level in which information can be freely offered and accepted by all concerned.

Step 2: Adults observe the young person at work, play, and rest in the home and school environment.

It is difficult to share a child's perceptions without entering into the child's environment. Adults should visit the classroom or playground to observe interactions by viewing the setting and participants together. Environmental influences come into focus when adults take this step toward learning about the whole child. Measurement tools can assist in the systematic collection of certain kinds of behavioral information, and some of these instruments are discussed in a later section.

Step 3: An adult initiates a conference among those who interact regularly with the child, i.e., family, teachers, peers.

Academic records, results of previous parent conferences, anecdotal statements, academic and psychological test results, health and attendance records are reviewed at this time. Meetings, among those whose contact with a youngster is extensive, are necessary so that the child retains dimension and is not reduced to a problem on paper. At the first meeting, all information including test interpretations acquired in Steps 1 and 2, is shared then reassessed by the conferees.

The first meeting is generally a difficult one as each participant has a vested interest which must be identified and respected. Opinions, as well as facts are aired; and, unfortunately, the child's presence could reduce participants willingness to speak openly. These opinions must be expressed,

however, since whether or not these are verifiable, conferees will interact with the youngster as though their individual assessments are accurate.

The purposes of consultation are conveyed best to the parents by the conference initiator when the first meeting time is arranged. Parents might feel uneasy or intimidated being at school and surrounded by school personnel; some care should be taken to assure parents that the purpose of these meetings is to determine what has been tried, how remediation is working and what other approaches can be undertaken cooperatively for the sake of the child. Parents' fears of being criticized, forced to choose sides and allocate blame among the family will then be allayed.

Step 4: Initial remediation is determined during this conference.

Conferees may decide either that a given problem is clearly within the scope of home and school intervention systems or that a particular case calls for further psychological and/or medical examinations. In many instances both psychological and physical health will require intervention and remediation. Well trained pupil personnel workers make their recommendation for counseling and psychological assessments at this stage in any referral process. The model being presented here places equal emphasis on an evaluation of physical health at this time.

Before a systematic remediation plan is designed, the observable components of a given case are compared to the overt symptoms of common childhood diseases, just as these symptoms have been considered in the psychological and cognitive realms. The school nurse, public health nurse or physician may provide their expertise during this stage of the consultation.

School staffs need a reference collection from the American Medical

Association, national foundations for special health problems and related agencies. This compilation provides an opportunity to become aware of some of the more common indicators of ill health. Alcoholism, diabetes, sickle cell anemia, epilepsy, allergies and malnutirition each have physical/psychological manifestations and, according to national statistics, often go undetected until the later stages. Consultation conferees need to become familiar with various concepts related to learning, stages of physical and psychological growth and development, and environmental influences. Both teacher and parent groups may evolve to study these important facets of child development.

The remaining steps of this intervention schedule are not as important for the youngster who can do multiplication but prefers to play; rather these later steps are meant for those whose concerns, behaviors and environmental interactions remain a puzzle. Whether or not an intervention encompasses both psychological/and medical referrals, remediation should include as much participation of the young person as of the concerned adults. Remediation is more successful if done with, rather than to, the student.

Step 5: Medical referral is indicated when the family medical history, environment, observable and reported symptoms singly or in combination raise doubts about the efficacy of psychological or learning process interventions as the exclusive modes of remediation.

A youngster whose family has a history of hereditary disease, or one who is not responding to systematic interventions of a conventional nature should be seen by a qualified physician. Referrals made in haste complicate rather than alleviate problems; therefore, available resources should be surveyed and evaluated before the need arrises. Ethical referral

agencies and professionals welcome investigation; a format will be presented in a later section to aid in this inquiry.

Step 6: Accurate anecdotal materials, compiled by school personnel, are made available to the clinic, agency or physician.

School records, containing behavioral anecdotes, are sent to the facility with parental permission. These anecdotes describe kinesthetic, emotional and learning patterns as well as interpersonal skills. No attempt is made to assign medical or psychological significance to these observations.

Teachers may need additional training to enable them to write behavioral anecdotes recording their systematic or casual observations of the child during school activities. This training is necessary because resource personnel often request information about teacher's judgement, as well as actual school performance, prior to or after the child's initial visit to a facility. To be useful, anecdotal information must be truly descriptive of behaviors rather than a collection of opinions, moral judgements or hearsay.

Behavioral anecdotes should record an incident, its duration, frequency and relationship to the environment. The statement, "Meg is cranky and cries all the time", is non-specific, judgemental and devoid of both causality and directionality for the reader. The writer of anecdotes should instead:

Give a description of the behavior: Since mid-October, Meg has cried, both silently and aloud, for as much as half an hour at a time, twice a week.....

Tell when the behavior occurs: Meg cries on Tuesday and Thursday morn-

ings immediately after her physical education class which meets at 10:00 A.M.

State what else accompanies this behavior: Meg complains of nausia and headache regardless of the nature of the physical education activities. She vomits 30-40% of the time and when this occurs, she cannot eat lunch.

Describe what behaviors follow the target behavior (crying): Meg sits as though exhausted and puts her head on her desk until lunch time (noon). Her breathing is rapid and shallow and her body is limp. Her face is pale and her hands are cold to the touch.

Report what occurs in the environment: Without a school nurse, school officials have taken Meg's temperature and kept a record of any heightened body temperature. Meg's parents have been notified but their work schedule precludes Meg returning home. Meg sometimes spends the period following P.E. resting in the principal's office. The other children do not interact with Meg if she remains in her homeroom. Initially, the teacher and Meg's classmates gave her attention but this seemed to worsen her crying.

Determine where else and when this behavior occurs: Meg does not cry or complain of other symptoms after recess or lunch periods when play is unstructured and Meg can choose her level of participation. This behavior has not been observed at any other time during school hours or at home.

Step 7: The clinic or medical facility provide information to the patient and appropriate other adults.

Clinics and doctors can be expected to provide the family unit, either verbally or in writing, with understandable explanations of any and all aspects of diagnosis, procedures and treatment. School personnel and parents should inform their referral sources of this expectation and request that useful reports be received within a reasonable period of time. "Understandable explanations" eliminate the possibility of either misinterpretation by lay persons or omission of health information when remediation is being attempted. It is cruel to subject a family to special kinds of medical and psychological testing, which raises their anxieties, and then subject them to a wait of 3 to 6 months for a report which does not provide prescriptive guidelines to help them or their child.

School personnel, even those who initiate a referral, need not receive diagnostic findings and reports except when specific recommendations require school participation and cooperation. Parents and resource professionals will determine which medical, psychological information and recommendations should be shared with individual school staff members. This exchange often takes place during a later parent-teacher conference and does not directly involve the doctor, agency or clinic.

Step 8: Follow-up meetings are scheduled by the referral initiator with the original conference members and any additional specialists who might assist with a proposed remediation.

When the school staff participates in remediation, periodic evaluations of a particular program and its effectiveness are useful. These later conferences encourage community confidence in the professionalism of school intervention specialists.

Those who use these eight diagnostic steps will find the procedure

requires more cooperation throughout and more time and energy within the early stages than other systems or no system at all. However, because the actual problem is defined, the duration of remediation may be shortened. Children who receive effective help return more quickly to the mainstream of school life and have a better sense of being able to cope than those whose treatment, while intense, is inadequate or inappropriate.

Section III

Referral agencies, especially medical and psychological facilities, should be located and evaluated prior to use by school professionals since referral to a facility is tantamount, in parents' eyes, to an endorsement.

In some communities, public service organizations provide directories which include an overview of available resources, as well as an indication, by omission, of community needs for which no service exists. An adequate directory lists those facilities serving the needs of the previously diagnosed individual, an exceptional directory lists diagnostic facilities and their capabilities. Family physicians, state and local American Medical Association chapters, and the telephone directory will provide the names of children's clinics, pediatricians, neurological pediatricians and the pediatric division of the nearest medical school. Psychometrists, school psychologists, mental health agencies, family counseling services and private therapists may be contacted through the American Psychological Association and the American Personnel and Guidance Association which have state and often local organizations.

Specific information should be collected, whenever possible, during a personal visit to the doctor, agency or clinic being considered as a resource unit. A visit, rather than a phone call or letter, furnishes valuable

insight into the general atmosphere of a setting and staff attitudes - intangibles which are seldom noted but which often determine the success of a referral. If professionals, as a possible source of clients, are treated discourteously or impersonally, then some of the families referred to that agency may be discouraged from accepting a diagnosis and instituting vital treatment. The following form has been used by counselors, counseling students and school personnel to aid in their evaluation of medical and psychological facilities.

MEDICAL OR PSYCHOLOGICAL FACILITY INFORMATION FORM

Name of clinic or physician_____Specialty_____

Address_____Office Phone_____

Access route from major highway_____Emergency Phone_____

Office Hours_____Emergency Hours_____

Patients are usually referred by _____other M.D._____agency_____School_____

_____self referred

Waiting period between initiation of referral and first appointment

_____days _____weeks _____months

Limitation of types of client seen by this facility_____

Average time required for initial examination and conference

_____less than 1 hour _____¼ day _____½ day _____1 day _____other

Is the patient seen by the same person throughout treatment? _____Yes _____No

Is the examination rushed? _____Yes _____No Are there numerous interruptions?

_____Yes _____No

COST: Initial examination $_____ Office visit $_____ Home visit $_____

hospital visit $_____ Lab fees $_____ Phone call $_____

Are lab fees billed from a separate facility _____Yes _____No

PAYMENT PROCEDURES:

If insured_____

If not insured_____

Installment or delayed payments_____

Provision for those unable to pay_____

Fees charged to complete insurance forms_____

PROCEDURES FOR PROVIDING INFORMATION & INSTRUCTION REGARDING PATIENT:

Office conference_____ with patient _____parents _____other

Phone conference _____ with patient _____parents _____other

Written report _____ to patient _____parents _____other

Time lapse between first visit and receipt of written report_____

Alternative to conferences_____

If feedback is not provided, what is the rationale for this omission?

_____

Does this facility request anecdotal and academic records from the school?

_____Yes _____No

If so, in what form?_____

Does this facility refer patients and families to counseling services when appropriate? _____Yes _____No

Does this facility _____encourage consultation with other specialists?

_____offer alternatives to radical treatment?

_____recognize and respect differences in moral and religious beliefs held by the patient and family?

_____believe in being truthful even if the truth is not pleasant?

_____explain satisfactorily to the client about the use of equipment and any unusual procedures, i.e., EEG's, stress testing?

What other services are available through this facility?_____

_____

**INTERPERSONAL INTERACTIONS

Are office personnel courteous? _____Yes _____No

Are the questions asked by receptionists and nurses within the scope of their authority? _____Yes _____No

Would the questions on the intake form be demeaning to _____a single parent? _____a bi-lingual person? _____a minority member? _____a person on welfare?

When both parents are present, do staff members consistently interact more with one parent than the other? _____Yes _____No Which parent?_____

Would the tenor of staff interaction with parents seem to regard them as:

_____over-protective _____bothersome _____unimportant _____unable to understand

Does the staff encourage questions from clients? _____Yes _____No

From parents? _____Yes _____No

When the facility is a hospital, is the doctor available to the family for questions at least once during the patient's stay? _____Yes _____No

When the doctor's hospital rounds do not coincide with parent visiting hours, how are family questions and concerns answered?_____

Are matters related to a patient's diagnosis and/or financial status discussed on the receptionists' phone?_____in the waiting room?_____

_____

Questions in the starred section of this survey (**) address the interaction among professionals and family and may not be immediately obvious. The tenor of the investigator's interaction, even the acceptance of this type of query, can provide some knowledge of how clients' questions will be

received. Granted that the main thrust of a professional referral is to accomplish an accurate diagnosis and proper course of treatment. Both are more likely to occur if the questions and feelings of the family unit are considered throughout the process. Better trained, more competent physicians and therapists recognize and respond to these needs.

It is absolutely essential to prepare the family unit for the initial visit when there is no choice to be made among several doctors, agencies or clinics. Sharing the kinds of information collected through the previous form can reduce a family's anxiety and keep their expectations and fears under control. An old adage seems apt here, "Forewarned is forearmed."

Special referral, in and of itself, often generates an over-reaction to the problem. Parents may experience guilt because they did not recognize the difficulty earlier; they may feel "inadequate" or "bad". Prior experiences with doctors and hospitals, fear of unfamiliar settings and apprehension about procedures remain in perspective when the referral initiator provides the family an opportunity to express their individual and collective concerns. The initiator should explain any general procedures a family will experience during their initial visit to a facility.

Those who make referrals provide emotional support when they show concern for a family and display objectivity about the referral process. While it might seem difficult to refrain from speculating aloud about any particular problem, it is inappropriate to tell the child or parents of similar cases, regardless of the outcome of those cases. At this stage of consultation, diagnosis is not complete and such stories tend to increase anxiety or build unrealistic expectations, and both hinder an acceptance of diagnosis and treatment. When the referral initiator is not

trained to counsel, an additional referral to a community mental health facility or private therapist may be the best way to ensure the family's emotional safety.

Schools have access to measurement instruments which aid in the systematic collection of observable behavioral information. Among these tools are the Devereux Rating Scales, developed in a clinical setting for several age groups and intended for use by classroom teachers after a minimum of one month's daily contact with the person being observed. The Devereux Scales provide descriptions of individual behaviors in relation to peer behaviors. A similar scale has been developed for use by parents and surrogate adults. The DESB profile may be utilized as part of a psychological consultation but its prime efficacy is in providing adults with concise examples of the distinctions among various normal and abnormal behaviors. The Barclay Early Childhood Readiness Assessment Scale and the Vineland Social Maturity Scale may also be used in data collection.

It is illegal to release information contained in cumulative records without parental consent; informed consent forms would be a part of any school's record keeping system. The content of his or her school records, and an explanation of the doctor's need for these records should be shared with the youngster who will then have a continuous sense of being part of the solution rather than of being the problem itself. Explanations are given appropriate to the child's age and need to know and either the parents or another person who relates well with this youngster may provide this information. It is important to respect the child's intelligence by telling the truth and using as much accurate terminology as possible.

Once a diagnosis is complete, treatment may take the form of a special diet, changes in sleeping and recreational habits, possible medication or surgery. If the diagnosis, prognosis and treatment are explained adequately to a family, the necessity of following recommendations can be more readily accepted. Families who understand the nature of diabetes do not reward their children's good behavior with candy. Parents of asthmatic and allergic children can regulate exposure to elements which precipitate respiratory distress when they understand the nature of those disorders. School personnel can be asked to cooperate by restructuring the youngster's school day or offering alternatives to participation in certain activities and these options should be available without unnecessary bureaucratic busywork or undue attention to the child's situation.

Educators have an even greater contribution to make to the field of health by teaching tolerance and understanding of individual differences. It is not uncommon for children who wear glasses or have braces on their teeth to be teased by their peers. The child who cannot participate in gym class is called names and rejected by those who have not learned to accept limitations in others or themselves. Being educated includes learning about the delicate and ever fluctuating balance between strengths and weaknesses in each human being.

Teachers may well wonder if, as examples for children, they model attitudes which encourage acceptance of the handicapped when that handicap is observable. Unless this kind of acceptance takes place, a less tangible handicap, such as learning disability or internal physical disorder will likely lend itself to scapegoating reactions in the classroom. There are few social areas with such potential for modeling acceptance or rejection as the classroom. Health units have been relegated too often to

the lowest priority of materials to be learned and the opportunity for children (and teachers) to learn about and accept their special qualities has been left to chance. Teachers can maintain a balance among physical, social and psychological aspects of health, attributing causation only when it adds to the understanding of individuals.

It is important to reiterate here that the teacher or consultant who gives expedient answers and dismisses children's physical complaints as mere attention getting behavior magnifies many children's problems. Further, onesided, inadequate case evaluation generates false expectations about the duration of the problem such that when resolution is slow or no progress is made, the family unit becomes discouraged and loses confidence in the school's ability to help. Thorough case analysis, however, inspires the level of interaction which enables children to freely describe and experience their physical and psychological worlds and encourages interventionists to become adept at effective remediation.

Section IV

The following case histories will be examined within the framework of the eight-step intervention schedule described in Section II. This exploration will illustrate how recognition of some of the observable physical symptoms of childhood diseases can alter the direction and thrust of intervention.

The emphasis will be on Step 4 which requires the comparison of observable aspects of each case with the overt symptoms of common diseases. Chart 1 is introduced to illustrate some of the errors likely to be made in defining children's problems, if the health factor is excluded.

Chart I

Disease	Symptoms	Misinterpretation of Symptoms
Alcoholism	extreme agitation disrupted learning patterns mood swings loss of concentration	quarrelsome forgetful spoiled flighty
Diabetes	fatigue intense thirst, urge to void and frequent urination sudden weight loss	poor sleep habits, too much T.V. disruptive, always wants to avoid work working mother and poor eating habits
Epilepsy	off and on contact with environment disruptive memory nervous & repetitious eye/hand movements	may be retarded short attention span, doesn't try to learn uses attention getting behaviors to disrupt
Sickle Cell Anemia	pains in abdomen, legs, arms fatigue frequent absence from school	immature, cries easily poor home life disinterested in school, no adequate models in home

*This chart is intended to indicate SOME of the possible pitfalls of making unverified conclusions from psychological/behavioral data exclusively. It is not intended to substitute for the inclusion of qualified pediatricians and neurological pediatricians in the referral process.

Case 1

Name: Alice X
Age: 13
Sex: Female
Family Physician:
Grade: 7
Parents: Married X Separated ____ Divorced ____ Deceased ____ Other ____
Siblings: 1 sisters 2 brothers
Ages: 2 9, 5

Home Address:
Home Phone:
Emergency Name and Number:
Parent Employment: Mother nurse
Father self-employed

Persons living in the home 6 : parents 2 siblings 3 others 1

School Attendance: Alice misses one or two days each grading period

Health: Vision and hearing screenings normal, routine medical care, adequate immunization record, no known allergies, scars, visible signs of handicap, no prior surgery or broken bones.

Academic Record: Elementary grades of B+ average began to drop at upper middle school. Alice is currently earning C's and D's; the D's are in Math and Science. She scored in the 7th percentile on nationally normed achievement tests administered in Grade 6.

Presenting Problem: diminished academic achievement

Referral Initiator: math teacher

Anecdotal Record: During the last three months, Alice seems highly agitated and unable to concentrate for from 5 to 30 minutes at a time regardless of the subject matter. She has difficulty sitting still for more than 3 minutes and complains of being bored. Alice has spoken openly to teachers and peers about dropping out of school. On several occasions she threw books on the floor and disrupted the class by being argu-

mentative. This behavior does not seem to be provoked by any one teacher or kind of peer interaction. Some peers reinforce Alice's outbursts by laughing. Teachers have attempted to handle this by ignoring her behavior until after class, then speaking to Alice privately.

Alice rarely initiates a conversation and does not complete her in-class assignments. These behaviors were not noted by teachers who taught Alice in previous years. Alice's parents have observed the same behavioral changes at home and Mrs. X, a nurse, suggests that Alice may be experiencing hormonal changes connected with the onset of puberty.

Step 1: Several adults listen as Alice speaks about her difficulties in school, her feelings, behaviors and physical symptoms.

The math teacher asked Alice to remain after school to talk about her incomplete assignments. Alice responded to questions vaguely and avoided eye contact with Ms. R.. Alice twisted on the chair and fidgeted with her hair, rings, bracelet. She described school as a "drag", teachers as "dumb", all in a voice that was subdued and toneless. Alice told Ms. R. she wanted to drop out of school and named several friends who felt the same way.

The counselor and Alice met for 3 sessions over a 2½ week period; then, with Alice's knowledge, the counselor scheduled a conference with other teachers and Mr. and Mrs. X.

Step 2: Adults observed Alice at work, play and rest in both school and home settings.

School personnel used observational guides to help them objectify their information about Alice's interaction with peers, classroom behaviors, lunch room and study hall activities. Alice's parents recorded her study habits at home and noted her sleeping, eating and activity patterns. Her parents and teachers also studied Alice's associates to determine if she had retained friends from previous years or had changed peer bonds.

The conference, Step 3, was scheduled two weeks in advance to allow time to collect and systematically record information about Alice which would expedite the initial conference.

Step 3: The counselor provided a suitable room and refreshments for the first conference which was attended by Mr. and Mrs. X, Ms. R. who had first indicated Alice needed help, Mrs. Q. the gym teacher, Mr. W the homeroom teacher, and the counselor.

Alice knew about the conference and was assured that any decision made in that meeting would be tentative and referred to her for her consideration. She was asked to attend a later meeting with some of the conferees and her parents.

The counselor moderated this meeting so that all points of view would be expressed and evidence could be weighed, avoiding any premature solutions. Ms. R. explained that she encourages completed assignments by allowing those whose work is complete to use the last part of Friday's class for games; she did not feel comfortable singling Alice out for individual reinforcement. According to Ms. R, Alice slept or rested her head on the desk several times during any given 50 minute period. Alice had re-

fused individual help and had remarked that she did not want Ms. R. to "hassle" her. Mrs. Q. physical education classes are quite large (60 students) and one-to-one encouragement can not be systematic but she had spoken privately to Alice about the possibility that Alice was forging notes which requested she be excused from certain activities or absent from class. Alice had accepted Mrs. Q's. confrontations with a shrug and continued to be minimally involved in any activity. The gym teacher had found Alice asleep on the floor under the bleachers once during the observation period.

During previous parent-teacher conferences with Mr. W., both parents reported that Alice did not respond to scolding, loss of privileges, praise or offers of material rewards for more than a few days at a time. In homeroom, Alice was tardy 4 times and became argumentative when Mr. W. asked for an explanation of her tardiness. The quality of Alice's school work was well below her ability level and she completed only 3 assignments satisfactorily during the two week observation period; 1 in math, 1 in English and 1 in Social Studies.

During Step 3 the adults' attitudes and interactions, which impinge upon Alice's situation, were explored by the participants. Ms. R. is a neighbor of the X family and had been a guest in their home. Her niece had been Alice's best friend during elementary school but was not in Alice's group of companions this year. Mrs. Q. was not sympathetic to young girls or their parents who use developmental functions such as menstruation as an excuse to limit physical activities. Mrs. X., Alice's mother, felt that, as a nurse, she was more qualified than a Physical Education teacher to recognize medical problems. Mr. W. planned to retire in the spring. He received Alice's classroom performance as evidence that parents in general

were not doing their jobs and suggested that Alice's parents might be too permissive. The counselor, with Alice's prior agreement, related that Alice seemed angry, confused and unable to sustain attention to school matters. She also indicated her suspicion, which she had not shared with Alice, that Alice and her friends were using marijuana.

During the discussion following these disclosures, no one's judgement or motives were challenged strongly, since arguments could either divert the group's attention or render further cooperation impossible. The first meeting is considered successful only if all parties are heard and their points of view accepted as valid but probably incomplete. Recognition of the actual situation is required from all participants at each step of intervention, diagnosis and recovery so the moderator must make a continuous and forceful distinction between acceptance (what is) and condoning (what should be). This kind of meeting can degenerate into uselessness unless the participants are guided to focus on the child's needs rather than on their own needs which usually include a desire to label and prescribe prematurely.

Step: 4: Several possible remediations were discussed; those which had been tried were examined for possible causes of failure such as inconsistency, time, lack of involvement on the part of Alice, etc.

The approaches to remediation discussed in Step 3 had produced little change in Alice as well as a good deal of frustration and confusion among the adults; the conferees decided to consider the following questions in order to establish some pattern within Alice's behaviors.

Was her drop in academic achievement really sudden? If so, how did each person account for this?

Alice reported that she was bored. Was her class placement satisfactory?

Did Alice exhibit physical as well as psychological signs of distress?

Was her loss of appetite real? Could she be eating away from home?

A pattern of behaviors and attitudes emerged during this discussion and it was noted that some of Alice's peers were known alcohol users. Alice had recently displayed:

a. diminished ability to sustain concentration regardless of subject
b. sudden drop in academic achievement
c. loss of appetite
d. mood swings at home and in school
e. change of friends from previous years.

When these behaviors were checked against some of the outward symptoms of alcoholism (Chart 1), there was sufficient similarity to warrent a medical referral.

Step 5: A medical referral was indicated because Alice's observable and reported symptoms singly and in combination raised doubt about the accuracy of other interpretations.

Alice's father volunteered that he had noticed quantities of liquor missing on several occasions from his home supply. An immediate medical referral was recommended and agreed upon since the incidence of moderate to heavy drinking in junior and senior high school students is currently estimated to be between 40-60%. The remainder of the conference was spent discussing the parents' and teachers' attitudes about the use of alcohol,

the addictive nature of this drug and whether or not school staff and parents could withhold religious and moral judgements about this disease so that remediation could occur, should that be the actual diagnosis.

Alice met the counselor and her parents after the general conference and was told of the recommendation for a medical examination. Alice agreed to participate. Her parents preferred to handle the confrontation about her possible use of alcohol privately after the initial visit to a physician. School authorities concurred with this more appropriate course of action.

Step 6: Accurate anecdotal material, compiled by school personnel and augmented by parent observation, was made available to the family doctor.

All written comments were read by Alice and her parents prior to the release of her file to the physician...a step which encourages accurate and non-judgemental record keeping. This information provided directionality to the doctor's examination and aided her in making an accurate and prompt diagnosis.

Step 7: The physician provided an explanation of the disease of alcoholism, its treatment and prognosis to Alice and her parents.

Social, ethical and moral contingencies accompany this disease, hence only Alice and her parents were told the final diagnosis, nature of treatment of the disease and its prognosis. School personnel other than the counselor, were not directly involved in remediation but supported Alice's attempts to improve her study habits and work assignments.

Step 8: Additional conferences about Alice's school work were held with various members of the original group and Alice.

School personnel were supportive of Alice's participation in school-

related activities. The X family learned that school personnel could treat their problems with dignity and confidentiality. At a later time, Alice and her parents discussed their participation in Alcoholic's Anonymous and Al Anon programs with the counselor, the principal and some of Alice's peers.

Case 2

Name: Nick
Age: 7
Sex: Male
Grade: 2
Home Address:
Home Phone:
Emergency Name and Number:
Family doctor:
Parents: Married X Separated_____ Divorced_____ Deceased_____ Other_____
Siblings: 1 Brothers 1 Sisters
Ages 16 18 (A 19 year old brother is recently deceased)
Living in home: Parents, 1 brother, sister in residential drug center
Parent Employment: Mother homemaker
Father steelworker

School Attendance: Nick misses 8-10 days each six week grading period

Health: Vision/hearing screening in normal ranges.
No physical handicaps, routine medical care.
Teacher and principal are concerned that Nick is allowed to stay home with his mother who is having difficulties adjusting to the accidental death of Nick's brother.

Academic Record: Scores in 8-9 stanine on nationally normed instruments
Grades of C and lower because of unfinished work.

Presenting Problem: emotional problem related to home situations

Referral Initiator: 2nd grade teacher

Anecdotal Record: Nick has difficulty concentrating more than 2-3 minutes across activities. He refuses to participate in free play or gym classes. Nick has the vocabulary, comprehension and complex speech patterns of a 10.8 year old but these skills do not transfer to classwork. He talks

aloud to himself for 5-10 minutes at a time but does not initiate conversation or play with peers. His motor skills are average as measured by the Purdue Perceptual Motor Skill Survey. Nick spends as much as an hour a day crouching under his desk. The other children have stopped playing with him or attending to his verbalizations or physical behaviors. The teacher has tried to confer with his parents and other teachers and has attempted to use a behavior modification treatment designed to extinguish his talking out. Parent conferences are difficult since both parents change the focus of the meetings from Nick to their own concerns. Nick's father is often incoherent and his breath smells of alcohol.

Step 1: The second grade teacher requested that the elementary school counselor meet with Nick. The counselor told Nick that his teacher, Mrs. K., was concerned with the quality of his work and lack of participation in gym and free play time. The counselor invited Nick to relate his opinions of the teacher's concerns. Instead Nick talked about a recent accident which took his 19 year old brother's life and expressed a desire to be home with his mother so she wouldn't cry. Nick said he felt lonely and was sure the other students in his class didn't like him. Nick wanted to please his teacher but he often couldn't remember what she wanted him to do. The counselor decided that, prior to another parent conference, it would be wise to determine the nature of Nick's peer interaction and classroom behaviors.

Step 2: Mrs. K., as well as the music specialist, the art teacher, the playground supervisor and counselor used observational guides to document the frequency and duration of Nick's verbalization and his climbing and crawling behavior across several classroom and play activities.

At the end of the observation period, these data were compiled and a conference date was established. This meeting included school personnel and Nick's parents. Nick's mother agreed to attend the conference and indicated she would represent his father's opinion and relate any decisions to him. Step 3: Nick was told that the conference was being held so that the adults could help him improve his participation in school. Nick needed assurance that he was "not bad" or "unloveable", only that his behaviors ran contrary to his welfare and his expressed desire to behave differently. At this juncture, it is crucial to gain a youngster's confidence so that he or she can understand that involved adults are interested only in helping to solve problems, not in being punitive.

The counselor served as moderator for the conference. Mrs. K., the second grade teacher, expressed her feeling that Nick had too much awareness of family problems and hence was unable to concentrate on things appropriate to his age. She reported that she had used "time-out" techniques, rewards and individual attention with Nick to no avail. She was currently trying to praise him for accomplishments that approximated the desired behaviors but Nick's attention span created problems within this approach.

Mr. B. felt Nick could excel in athletics but did not do so because of fears instilled by his brother's death and his parent's willingness to keep him home for relatively minor illnesses. Mr. B. initially encouraged and coaxed Nick to participate in class, then decided to put him on the sidelines and go on with the other 40 students. This later procedure had been the rule for the past 2½ months.

Mrs. P., the play ground supervisor, noted that Nick actively refused offers to play with other children and slipped back into the school building 2 or 3 times a week. Mrs. P. was concerned when Nick violated school rules

since she felt responsible for him. She tried making him a helper, giving him the whistle to blow at the end of recess, but Nick did not seem to regard this as a privilege.

Nick's mother was apologetic and tearful; she talked at some length about how no one understood Nick any better than his dead brother had been understood. She related that Nick was physically sick but their family doctor treated her as though she were neurotic when she requested examinations for the boy. The doctor's attitude had begun 5 years ago when Nick and his mother were involved in an automobile accident. Nick was thrown through the rear window; he convulsed for 45 minutes immediately afterward and was hospitalized for a week. Since then, Nick's mother had taken him to the family doctor for illnesses which the doctor dismissed as "trivial". Nick's mother had considered changing doctors but was afraid their family physician would garnishee her husband's wages.

Step 4: Given the seriousness of the previously unrecorded accident, the conferees decided to initiate referral to a neurological pediatric clinic in the nearest major city. Nick's incident of prolonged convulsion was sufficient justification for this referral.

Step 5 and 6: Observation and anecdotal records collected in Step 2 were shared with the staff of the hospital; Nick's previous medical record was released to the hospital.

Nick and his mother were prepared for their visit to the neurological clinic by the counselor who discussed the kinds of tests which would be used and how Nick could cope with hospitalization.

Step 7: This examination determined that Nick experienced 20-30 subliminal petite mal epileptic seizures daily; and a medical regime was initiated.

School personnel were asked to modify Nick's required school activities based on his medical diagnosis and he was excused from gym and free play until his condition stabilized. The rationale for exclusion of activities and medication were explained to Nick so that he would not feel punished by any of the necessary restrictions.

Step 8: Nick's mother and his teachers held several follow-up conferences. The mother was very cooperative once she had been listened to and her concerns confirmed and acted upon. Nick's teachers reassessed their prior judgements of Nick and his family and provided support for his gradual reinvolvement in school. Nick received counseling about the loss of his brother and other personal concerns.

This case illustrates several important points:

1. a child may have physical and psychological problems simultaneously
2. the observable symptoms may or may not converge into a single problem
3. a problem may require the intervention of more than one specialist
4. successful outcome depends upon the further cooperation of each specialist.

Case 3

Name: Jerry
Age: 11
Sex: Male
Grade: 5
Home Address:
Home Phone:
Emergency Name and Number:
Family doctor:

Parents: Married X Separated _____ Divorced _____ Deceased _____ Other _____
Siblings: 5 Brothers 4 Sisters
Ages: 25-16 19,16,15,12
Living in home: Parents, 2 brothers, 3 sisters, maternal grandmother

Parent employment: Mother store clerk Father tool & dye maker

School Attendance: Absent 18 days, Jan. 7 - March 31.

Health: Vision/hearing screening normal, no visible signs of deformity. No evidence of routine medical/dental care.

Academic Record: B average in 3rd grade and early part of 4th grade current grades range from C to F (Grade 5)

Presenting Problem: possible eligibility for psychological testing and EMR placement

Referral Initiator: Homeroom Teacher

Anecdotal Record: Since Fall of this year, Jerry has been involved in fighting on 6 occasions. Twice he gave the other child a bloody nose. Once he tried to use a baseball bat to hit the other child. Peers and supervising teachers reported that all 6 incidents seem unprovoked.

Jerry does not work cooperatively in groups either socially or academically. His reading and writing skills are 2 years below grade level and his aggrevated absences resulted in his losing an opportunity for tutoring with a remedial teacher.

Jerry is small for his peer group and does not appear to have much stamina. His outbursts of fighting are followed by 1/2 to 1 hour periods where he seems exhausted. Jerry's homeroom teacher has requested parent conferences but both parents are employed and no appointments have been kept. The science and social studies teachers, as well as the homeroom teacher, feel that Jerry is a borderline EMR and want him tested so that he may be placed in special classes.

Step 1: Jerry met with the school counselor to discuss alternatives to and some possible causes of his aggressive behaviors. Jerry related that he had "mad" feelings sometimes that just "happened". He told the counselor that he ate his school lunch and went to bed by 10 p.m. but always "felt bad". Sometimes he "ached all over" and the pain made him "want to hit somebody". Jerry found 5th grade work much harder than the work in the previous grades and said he knew one of his teachers and the principal "hated" black kids, (an observation the counselor knew to be accurate). Jerry's voice, throughout the counseling interview, was devoid of inflection and he seemed too tired or disinterested to pursue any part of the discussion for very long.

Step 2: The counselor, homeroom teacher and subject specialists used The Devereux Rating Scales to record observations of Jerry in class and on the play ground. This observation period lasted 3 weeks.

Step 3: The counselor arranged for an evening conference in Jerry's home which would be attended by Jerry's teachers, the counselor and the remedial reading specialist who had tested Jerry early in the fall of the current school year.

At the meeting, the reading specialist, Mr. Q., interpreted Jerry's reading test scores and discussed the possibility of further diagnostic testing for Jerry. Mr. Q. felt Jerry was not motivated to participate in individual or small group sessions and had replaced Jerry with another student in his reading classes.

Mrs. F., who was Jerry's homeroom teacher, described her attempts to involve him in class activities. She had used rewards, both material and intangible, and had requested several parent conferences. She questioned Jerry's sleeping habits because he acted tired even when he first arrived

in the morning.

Ms. L., the science teacher, had been the supervising adult during 4 of the 6 fighting incidents. She made several attempts to talk to Jerry about his behavior but she expressed fear since his outbursts did not seem provoked. Ms. L. stated that she was marking time until Jerry was tested and assigned to special education and she didn't intend to upset him during that interim.

Jerry's parents expressed a willingness to cooperate with the school but refused to consider psychological testing. They told the conferees that white teachers labeled all blacks "retarded" and placed them in EMR classes rather than get down to the business of teaching. The parents were adamant on that point. Jerry's mother had observed his temper at home but felt the older children tormented Jerry.

Step 4-5: In Jerry's case, only his prolonged absence from school in January pointed toward actual health problems. However, it is often easier for parents to accept psychological testing and its outcome once physical problems have been explored and/or eliminated. Both parents agreed to a complete physical examination at a local clinic. Jerry's father's medical insurance would cover the cost of this examination and their final objection was removed.

Step 6: Anecdotal materials and school records were requested by the clinic prior to Jerry's first visit. Parental permission was obtained for release of these materials.

Step 7: Jerry's entire family was referred to the clinic after a preliminary diagnosis of sickle-cell anemia was confirmed. Jerry's treatment and prognosis were explained to him and his parents and the older siblings were referred to a local university for genetic counseling.

School personnel modified Jerry's school program and provided a home-bound teacher when Jerry could not attend school during the colder months of the year.

Step 8: Follow-up conferences were held during the next year with Jerry and his parents. An increase in Jerry's absences and several hospitalizations were discussed among the teachers and the implications of these hospitalizations were explained and discussed with the family unit. Jerry was placed on the school's home-bound study program permanently one year after the initial identification of sickle-cell anemia.

Case 4

Name: Paula
Age: 9½
Sex: Female
Grade 4
Home Address:
Home Phone:
Emergency Name and Number:

Parents: Married_____ Separated_____ Divorced__X__ Deceased_____ Other_____
Siblings: Brothers__1__ Sisters__0__
Sibling Ages: __4 mos.__
Living in Home: Paula lives with her mother and infant brother born 1 month before the parent's divorce. She visits her father one day a week.

Parent Employment: Mother: High school teacher (math) Father: golf pro

School Attendance: 1 or 2 days absence a year

Health: Vision and hearing screening normal. Record of usual childhood diseases, no complications. No observable abnormalities. Sharp weight drop in the last 6 months without other noticable problems.

Academic Record: Paula scored in 6-8 stanines on nationally normed achievement tests given in Spring of previous year. Her grades began to drop during the time when her brother was born and the divorce of her parents occured.

Presenting Problem: General unhappiness.

Referral Initiators: Mother and teacher

Ancedotal Record: Paula has become less active in the classroom. She does not complete her assignments or volunteer to read or answer questions. She complains to the teacher of having too much work to do and often seems listless. These behaviors occur both at home and at school. Paula requests permission to rest, get a drink, go to the restroom at least once every hour. Mother and teacher see this behavior as avoidance. Paula eats her full lunch and several snacks a day but has lost 10½ lbs. this year. She cries whenever she loses her place in line or some other child wins a game. The crying is new behavior emerging in the last 6 months. Paula has stopped playing with her peers at recess and frequently sits beside the school building or clings to the playground supervisor.

Step 1: Mrs. Z, Paula's mother, and Mr. R., the teacher, talked with Paula about her parent's divorce and the arrival of the baby. Paula insisted she loved her brother and was not "very sad" about daddy moving away. When asked about her school work, Paula cried, refused to talk, and kept promising her mother that she "would be good".

At the mother's request, school staff members observed Paula in various settings and recorded their findings. Particular attention was paid to the events which preceded Paula's request to have a drink and/or go to the restroom. Time of day and the frequency of the requests were noted. Paula's mother kept a similar record at home to see if Paula used "avoidance" behaviors when asked to do tasks at home.

Step 3: Paula was told that her teachers and parent intended to meet to discuss how they might help each other help Paula.

Recorded observations of Paula's requests for water and restroom access did not establish a pattern of avoidance of school or home tasks, but rather were consistent by time accruements across situations and placement.

Mr. R., the classroom instructor, had talked to Paula about missing her father but felt Paula either could not express the degree of grief he supposed her to have about her father's departure or did not experience a great degree of grief. He thought either reaction was inappropriate, but did not feel he was trained to counsel her.

Paula's mother expressed guilt feelings that she had been so involved with her pregnancy and marital problems she might have ignored Paula's needs. Mrs. Z also wondered if her daughter felt rejected by either parent and might be reverting to immature behaviors to regain her parents' attention. She had expressed these feelings to Paula who assured mother that everything was fine.

Step 4-5: Paula exhibited some physical symptoms which could be compared with the overt symptoms of diabetes. Paula's paternal grandmother was diabetic so the conferees decided to initiate a medical referral and to request that Paula participate in counseling at the local mental health facility.

Step 6: The family doctor requested academic records and teacher observations which were released with parental consent.

Step 7: A diagnosis of diabetes was confirmed and medication prescribed. The doctor notified the teacher and mental health therapist of some possible problem areas which Paula could experience---restricted diet and daily medication. The physician further explained the possibility of Paula rejecting the diagnosis: some diabetics deliberately forget to take their medication when angry at their parents or siblings. The change of diet (no junk foods

or sweets) can percipitate irritability. School personnel were cautioned to treat Paula as they would any other child of her age and to avoid calling undue attention to her physical problems.

Step 8: Mrs. Z contacted the school and conferred periodically with school personnel. Paula received the necessary support at home and in school to accept her restrictions and return to her previous level of academic achievement. Her crying behavior extinguished as her health problem stabilized.

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